Building Support for Coordinated School Health Programs

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Abstract

This study sought to identify successful strategies for garnering stakeholder support for coordinated school health programs (CSHP) – an interactive, multi-component approach to health promotion among students and school staff. In the late 1990's several states were awarded federal funding to build infrastructure for CSHP. Directors from these states previously participated in interviews pertaining to their accomplishments directly related to this funding. A three stage, qualitative study utilized this interview data along with follow-up interviews and document analysis to compile a list of successful support-building strategies. Using the diffusion of innovations model, effective support-building strategies were drawn together and areas of weakness were identified.

A multitude of chronic health problems experienced by adults result from unhealthy behaviors adopted in childhood and adolescence. To illustrate, the best predictors of adult obesity and smoking – the top causes of morbidity and mortality (Johnson, Dominici, Griswold, & Zeger, 2003; Mokdad, Marks, Stroup, & Gerberding, 2004) – are overweight and tobacco use in childhood and adolescence (Salbe, Weyer, Lindsay, Ravussin, & Tataranni, 2002; Spooner, 1999). Hence, the Centers for Disease Control and Prevention (CDC) recommend adoption of healthy behaviors early in childhood to prevent chronic disease in adulthood. This is the goal of coordinated school health programs (CSHP).

CSHP is a concept that focuses on creating a health-promoting culture inside and outside the school to encourage, support, and reinforce students' healthy decisions to set the stage for a healthy lifestyle in adulthood. In addition, CSHP strive to improve students' health thereby improving academic performance (McKenzie & Richmond, 1998). The approach involves coordination of health programs across a variety of components including (1) physical education that teaches students how to incorporate physical activity into their daily lives, (2) health education that provides students with health-related knowledge and skills, (3) health services that provide basic screening and health care for students, (4) counseling and psychological services that provide support for students dealing with emotional or adjustment challenges, (5) healthy school environment that provides a psychologically and physically safe and clean learning environment for all students, (6) nutrition/food services that provide healthy meal and snack choices, (7) health promotion for school faculty and staff so as to provide students with healthy adult role models, and (8) family and community involvement to support healthy lifestyle choices outside of the school (Marx & Wooley, 1998).

To facilitate the adoption of CSHP, the CDC's Division of Adolescent and School Health offered funding to states on a competitive basis for development of infrastructure to support statewide implementation of CSHP. Funds were utilized to support personnel at state education and health departments with responsibilities to provide direction, coordination, training, and technical assistance for CSHP in school districts statewide. Part of this initiative included garnering support from key stakeholders (e.g., teachers, administrators, and parents). Expected outcomes of CSHP included improved student health and decreased risk for developing chronic diseases later in life as well as enhanced school attendance and educational achievement. More specifically, CSHP focused on tobacco use prevention, adequate physical activity, and proper nutrition.

Initial stages of infrastructure development involved introducing CSHP to stakeholders and garnering support. Rogers' (1995) diffusion of innovations model highlights processes and stages associated with the introduction of innovations such as CSHP. The model predicts that stakeholders progress through a series of stages leading to adoption or rejection of the innovation. These stages involve information gathering, attitude formation, decision to adopt or reject the innovation, utilization of the innovation, and reinforcement seeking – all leading up to continued implementation or rejection. Individuals initiate adoption at different points in the introduction of the innovation and progress through stages at different rates. That is, some adopt the innovation rather early (innovators), while others have delayed response (laggards) (Rogers, 1995).

Successful adoption of an innovation is dependent upon information communicated by a change agent. The change agent must develop a need for change, create intent to change, translate the intent into action, and assure continued adoption (Rogers, 1995). In the case of the CSHP, the state-level CSHP directors working in departments of education

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and health served as change agents. The current study focused on the diffusion strategies used by the state-level CSHP directors to introduce and garner support for CSHP from stakeholders. Of particular interest were strategies that translated intent into action (e.g., formation of CSHP coalitions) and continued adoption (e.g., involvement in CSHP activities). These action-oriented strategies are particularly important because implementation of new programs in schools is often met with resistance (Norris, 2003) stemming from increased pressures placed upon schools by federal mandates to meet minimum educational achievement standards such as those set by the No Child Left Behind Act (United States Department of Education, 2001).

In 2000 and 2001, a PhD level school health professional with assistance of a support staff person from the Academy for Educational Development conducted one hour guided interviews via telephone with two to three staff members from 15 of the 20 states that had received funding for CSHP infrastructure development (Lohrmann, Thomas, Coleman, Anderson, & Schlagel, 2001). Five states excluded from data collection were newly funded and thus could not provide meaningful input. The primary objective of these interviews was to explore the accomplishments of CSHP in each state that were directly linked to the CDC funds. Some unanswered questions that arose from the prior study arose served to guide the current study. What was the initial level of stakeholder support for CSHP? What buy-in strategies were implemented by CSHP directors? Which strategies were perceived as successful in garnering buy-in and support from schools for CSHP? Conversely, which strategies were perceived as unsuccessful in garnering buy-in?

Method

Design and Procedure

To investigate levels of initial support and strategies used to boost local support for CSHP, a three-stage qualitative case study was conducted. Stage one consisted of a review of interview transcripts and summaries from interviews with CSHP directors from the 15 infrastructure states (Lohrmann, Thomas, Coleman, Anderson, & Schlagel, 2001) to develop an interview schedule for stage two. Stage two consisted of follow-up interviews using an interview guide approach with a convenience sample of three state directors. This approach allowed for flexibility in the order and wording of questions. Stage three consisted of a non-participant observation in the form of a document review that included websites and conference materials. All three stages were undertaken by a doctoral student enrolled in a qualitative inquiry course.

Stage 1. Review of interview transcripts and summaries (Lohrmann, Thomas, Coleman, Anderson, & Schlagel, 2001) uncovered comments pertaining to a variety of strategies including team formation, mini-grants, and marketing campaigns that potentially influenced local school support for CSHP. In addition, summaries revealed a surprising array of collaborative partners that included private businesses, schools of education at colleges and universities, the National Guard, and professional sports teams. These strategies and collaborations raised the need for further clarification that were addressed via follow-up interviews. Table 1 includes a sampling of questions probing these content categories, which included history and infrastructure, community readiness for CSHP (an assessment of initial support), buy-in strategies implemented, and collaboration-building. These questions were included in the semi-structured interview (Stage 2) along with questions specifically tailored to individual state directors based on prior interview responses.

Stage 2. Interviewees from states previously involved in 2000 or 2001 interviews were contacted via email and asked to participate in a 30 minute follow-up telephone interview. An Institutional Review Board approved study fact sheet was sent along with this first email so that participants understood the nature and purpose of the study prior to agreeing to participate. The first three directors contacted agreed to participate in the study and interview times were scheduled. Given the multi-stage nature of the study, a limited number of participants were sought for follow-up interviews to allow for more in-depth analysis of individual participants. All respondents were females from Midwestern states. Though gender and geographic location may play a role in support-garnering strategies, these were not variables of interest and a lack of variation was not a concern. Anonymity was assured and each participant's state affiliation was recorded.

The semi-structured interview protocol incorporated questions in Table 1 along with questions specific to each state. This type of interview protocol provided a core of common questions while allowing some flexibility in the questions posed by the interviewer. For example, one interviewee was asked, "In a previous interview, it was mentioned that colleges and universities were incorporating Health Education Content Standards into teacher preparation programs. How was this collaboration established?" During each interview, responses were recorded by typing field notes into a word processing program via computer. Upon conclusion of the interview, respondents were thanked for their time and asked, "Is there anything else that I forgot to ask or that would be important for me to know?"

Stage 3. All respondents provided additional information in the form of referrals to related websites or CSHP conference documents. These documents were the focus of stage three of the study. Documents were analyzed for common themes using an unstructured observation protocol for the purpose of triangulating on findings from stages one and two.

Analysis

Content analysis was used to scrutinize responses and documents from all stages of the study. Common themes were extracted along the categories listed in Table 1 and compiled into a list of successful support-building strategies.

Table 1

Semi-Structured Interview Questions

Subcategory	Question
History and infrastructure	-How did it come about that your state applied for these CDC funds?
Assessment of community readiness for CSHP	-When your State initially received CDC funds, how supportive were school administrators of implementing CSHP? -Initially, how supportive were teachers of implementing CSHP?
Accounting of buy-in strategies implemented	-Did you offer any incentives to schools for participation in CSHP? -Were there any strategies implemented that failed to increase support for CSHP?
Collaboration-building	-Were private businesses approached for assistance? -Did you approach businesses with a track record for charitable giving to youth causes?

Trustworthiness of findings was assured by employing a multi-stage approach to triangulate on successful strategies. These strategies were viewed in the context of Rogers' (1995) diffusion of innovations model in order to identify strategies that were successful in garnering buy-in and adoption of CSHP.

Results

All three stages of the study yielded a wealth of data revealing perceived role of directors and initial levels of support as well as successful support-building strategies, collaboration-building, and solutions to unanticipated problems. Some areas of improvement were also revealed. Each will be discussed in turn.

Throughout follow-up interviews, directors continually alluded to their role as change agents in the diffusion of CSHP. For example, one respondent described their coordination of the drafting of a consensus paper on obesity. She noted that after the release of the paper partners increased and enthusiasm began to spread. Clearly, the respondent recognized and celebrated that her actions resulted in increased support for CSHP – characteristics of a change agent.

Initial levels of support for CSHP varied between states. Those identified as showing support early in the diffusion process included pro sports teams, state governors, local academicians, professional health organizations, and teachers. Late adopters included private businesses, school administrators, and teachers. Interestingly, teachers were mentioned as early and late adopters, which may indicate variability in the communication channels utilized and target audience of support garnering strategies.

Directors revealed a number of successful strategies for garnering support and buy-in for CSHP from stakeholders. First, each state offered incentives to schools, administrators, and teachers for involvement in CSHP activities (e.g., conferences and trainings). Incentives included mini-grants, scholarships to trainings (to cover substitute teacher pay when teachers were away for trainings), and free or discounted materials and curricula. Formation of teams or coalitions focused on CSHP was a second common strategy. Sometimes receipt of incentives was tied to the formation of teams. For example, mini-grants were awarded to teams only rather than individuals. One respondent noted that it was not the money that made the incentive so successful, but the formation of a local CSHP team. She went on to say that the formation of a team took them far beyond where they could have progressed otherwise. Third, all respondents reported that their state highlighted the positive effects of CSHP on students' academic performance in an effort to garner support. One state utilized the slogan "Eat Healthy + Play Hard = Smart Students" to accentuate the relationship between healthy students and academic achievement "right up front".

Directors also provided insight into collaboration-building. First, some states forged relationships with local businesses. Though many of these businesses initiated their collaboration after witnessing the success of CSHP (e.g., upon implementation of a policy banning soda machines in schools, bottled water distributors joined on as collaborators), directors strategically approached businesses without a track record for charitable giving or collaboration with youth-serving initiatives. These businesses were targeted because they were less likely to be involved with other initiatives and more likely to have resources to contribute. Directors also noted that part of successful collaboration-building is knowing when collaborations are no longer useful. For example, one state partnered with a media outlet to market CHSP to the target audience (parents

and youth). However, once the audiences were saturated, the directors recognized that the relationship had served its purpose and that it was time to seek other partners.

Over the course of the analysis an overarching strategy affecting support and collaboration-building surfaced. Though directors resided in state-level agencies and their influence was somewhat limited to upper-level administrators and collaborators, they made an effort to model within and between state agencies the behavior they wished to inspire in local school districts. Directors encouraged similar collaboration, evaluation, and implementation of CSHP at the local-level. For example, one state sponsored a CSHP conference and made the conference materials available for review. These materials included an extensive list of collaborators and a progress report on established objectives – necessary for successful partnerships and accountability. In addition, conference activities included healthy meals and recess – behaviors targeted by CSHP.

When asked about strategies that were unsuccessful in building support for CSHP, directors shared examples of problems that arose along the way as well as lessons learned. One director said that early in the process, they were having difficulty garnering support from schools. They realized that many administrators and teachers were unclear about the nature of CSHP (an approach rather than a specific set of activities). Once the message was tailored to the audience and put into their vernacular, support began to build. All respondents reported having limited interaction with parents (beyond parent-teacher associations and organizations) and limited awareness of the level of parental support for CSHP.

Discussion

Results revealed important insights into the perceived role of directors and initial levels of support as well as a number of successful support, collaboration-building, and communication strategies utilized by CSHP directors. Acting as change agents, directors assessed initial levels of support exhibited by various stakeholders and implemented strategies to garner greater support. Participants reported that these strategies enhanced the infrastructure as they created collaborative ties between CSHP supporters (e.g., teachers and school administrators). These ties facilitated the translation of intent into action and continued adoption of CSHP.

Respondents reported little or no connection between state-level CSHP directors and parents – a critical component of the community as they are "children's first and foremost health educators," (Lohrmann & Wooley, 1998). These findings mirror those found by the School Health Policies and Program Study (Kolbe, Kann, & Brener, 2001) conducted by the CDC. Results revealed that while the majority of schools were reaching out to families to provide them with information about CSHP, very few met with parents' organizations or offered any health education or physical activity to families. This apparent disconnect between those implementing CSHP at the state level and parents highlights a priority area that deserves attention. "To ensure the successful implementation and sustainability of an educational innovation such as a coordinated school health program, the external environment – the school district *and* the surrounding community – must support the program," (Fetro, 1998, p. 35) [emphasis added]. Not only is the home and community environment important to children's health due to the amount of time spent outside of school, but also the family and community are critical to sustainability (Lohrmann & Fors, 1986). If funding disappears and the schools can no longer shoulder the CSHP effort, the family/community unit will be left with the task. One respondent noted that CDC funds were not renewed and that without the support of the community (private businesses, in particular), CSHP would not have been able to continue. One respondent provided a rationale for their focus on higher-level stakeholders (e.g., school administrators and teachers) rather than parents when she noted that they had not gotten to the level of the parents yet. Rather, they were trying to enhance collaboration at the state level with schools so that schools could reach out to parents.

Intuitively, those components that lie outside of the confines of the school seem most difficult to access. Perhaps change agents have not successfully utilized the diffusion network and disseminated the message through appropriate communication channels. Implicit in the reported strategies was the idea that the CSHP message would be focused on the higher-level individuals (e.g., school administrators) and that the message would trickle down to stakeholders at the local level, including parents. That is, state-level directors expected that those higher up in the local communication chains would pass the message along to parents. However, this may not have been the case. Future studies should investigate these and other possibilities.

It is recommended that state-level CSHP directors target parents for diffusion of CSHP innovation by initiating more direct contact with parents and the community at-large to assure support from these very important stakeholders. "Parents can be strong advocates when convinced that a program contributes to the welfare of students," (Centers for Disease Control and Prevention, Division of Adolescent and School Health, 2002). As enumerated by Lohrmann and Wooley (1998), state-level directors can support family and community involvement in CSHP by enacting health policy, educating families and communities about school health concerns, creating evaluation systems, requiring a family and community component for all school health grant proposals, and launch awareness/social marketing campaigns targeted toward family/community. In addition, state directors could develop and offer specific workshops for local teams on how to engage and recruit parents as well as community agencies, organizations, and businesses. Finally, states should encourage involvement of highly respected, influential parents to "champion" CSHP at the local level.

Acknowledgement: The Authors would like to thank Dr. David J. Flinders, Professor in the Indiana University School of Education, for his helpful comments and suggestions on drafts of this manuscript.

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